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RUSSELLVILLE, (Ky.) March 5th, 1843.

To the Editor of the Medical Examiner.

Sir,—On reading the lecture of Prof. Chomel on "Hepatic Colic," published in the Medical Examiner of the 11th February, I was induced to refer to the subjoined notes of an interesting case, which happened in my practice some years since. They are imperfect in many respects, as you will see, having been taken with no view to publication, but only to keep the more important points of the case in recollection. Should you deem them of sufficient interest for the columns of your journal, they are at your disposition.

I remain yours, respectfully,
J. R. BAILEY, M. D.

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Mr. F. T——s, a middle aged man, had, up to the 22d December, 1838, suffered from occasional severe attacks of colic for the last eight years, from which he generally recovered in about a week or so. He always noticed that his alvine dejections, for some days previous to these attacks, were of a whitish, clayey appearance, and invariably assumed a very dark colour, with purging, as the symptoms of colic declined.

He likewise observed that the attacks were more frequent latterly—having come on once a month, or once every fortnight; whereas, formerly, there was an interval of two, three, or even six months. Although they had varied much in severity, yet he could not say that they were more violent as they became more frequent. He had at various times taken some Thomsonian remedies, which, though they greatly relieved the pain at the commencement of the attack, did not sensibly shorten its duration. He had rarely felt well for the last six months; complained of a dull pain in the region of the liver, with loss of appetite, and occasional nausea. A few weeks before this time he had suffered from a severe fit of colic, followed by a diarrhœa, which, persisting longer than usual, rendered him very weak.

At the above date he was also labouring under irregular intermittent fever. The nausea had become constant, and his countenance presented a sallow hue. A mercurial treatment, (short, however, of ptyalism,) was adopted, which checked almost instantly the intermittent fever; however, at the end of two weeks, there was no perceptible improvement in other respects. I considered ptyalism necessary; and for that purpose directed calomel (two gr.) regularly every six hours, and his right hypochondrium to be rubbed with an ointment containing calomel and tartarised antimony, until the gums became sore. This was effected in a few days, and a copious crop of pustules brought out. A decided amendment was soon evident. His improvement was rapid, and his appetite became even ravenous. He considered himself entirely well; but his wife still noticed an occasional flushing of his cheeks.

Whilst Mr. T—— was busily engaged in his farming operations, he was attacked with colic on 16th March, 1839. The attack was lighter than usual. His alvine evacuations had some days before assumed the clayey character; and although I had warned him of the necessity of taking medicine, immediately on perceiving such a state of things, yet he had neglected my admonitions, thinking "a man with so good an appetite could be in no danger." The following pills were ordered, one every fourth hour.

R. Hydrarg. Proto-chlorid.	ʒss.
Ipecacuanhæ,	gr. vi.
Syrupi Simpl.	q. s.

Ft. pil. vi.

In twenty hours large bilious evacuations were produced, and he was very much relieved. No salivation resulting from this course, and the patient being averse to undergo this process, I was induced to try the nitric acid. He commenced with six drops, and increased it to ten, but with no sign of improvement; (he, however, only used it four or five days.) On the 22d, being called in haste, I found him worse than at any previous time. I gave an active emetic of ipecacuanha, with no apparent benefit, followed by a mercurial cathartic, which relieved the urgent symptoms, and I proceeded to induce ptyalism in the same manner as formerly.

The relief was such, that on 4th April, while his gums were yet tender, he ventured abroad (contrary to orders, however,) to superintend his farm. On 6th he felt somewhat worse. Soreness of the gums subsided, on the supervention of a severe rigor, on the evening of 7th. The rigor continued for two hours, with excruciating pain in the stomach and right hypochondrium. A burning heat of skin followed, of about two hours duration, succeeded immediately by a second and even a third rigor, each following the course of the first. During these twelve hours he suffered the greatest agony. After the third rigor I gave the sulphate of quinia, in conjunction with the calomel he was again taking. The rigors ceased; but still he complained much of his side, and particularly of his stomach. Dr. Withers saw the patient with me on 8th, and, at his suggestion, an emetic of ipecac. was administered, the calomel increased from four to eight grains every four hours, and given in combination with carb. iron, &c. Although not salivated, his dejections in forty-eight hours became bilious. The colour of the evacuations at this time was ashey; they were likewise foamy; a tinge of greenish yellow was barely perceptible. (Bile, having the same characters, was found, on the post-mortem examination, in the stomach and excretory ducts of the liver.) He was much relieved of his sufferings, but the nausea continued as distressing as at any time, with occasional pain in the stomach. No complaint of the right hypochondriac region. He sunk gradually—indeed, I may say rapidly,

and died on 21st April, sixteen days after his last attack.

Although several remedies were prescribed at various times, yet nothing seemed to relieve him except calomel and counter-irritation by tart. emet. and a blister was once applied to his side.

During the latter part of his sickness his pulse was exceedingly feeble and small, and not increased in frequency.

Autopsy thirteen hours after death. (Time limited.)

Body much emaciated.

Head not examined.

Lungs and heart sound in every respect.

Stomach nearly empty, containing only a few ounces of viscid matter coloured with bile, as mentioned above. Several cicatrices were apparent on the mucous coat—the largest about the size of a 25 cent piece. The whole of the great curvature was strongly injected with blood, and the posterior portion of the curvature was of a dark brown colour. Mucous lining injected throughout.

Bowels healthy, except that part of the transverse arch of the colon which lay in contact with the stomach. This part was, as the stomach, strongly injected.

Liver of a natural colour, except the posterior edge of the right lobe, which presented a brownish red colour; and a small portion of the anterior edge of the same lobe was of a dark venous hue.

On cutting into the right lobe, commencing on the convex surface, and proceeding in the direction of the portæ, I noticed on one side of the incision a marked difference of colour. Fluctuation was evident to the touch. I opened it, and a fluid foamy bile, as described above, made its exit, and showed the sac to be a distended portion of one of the excretory ducts—the bile being prevented from passing by a small gall-stone. It was of a jet black colour, easily reduced to powder by rubbing between the fingers, to which it communicated a deep, though bright yellow colour, as it did also to water. On examining my incision more particularly, I found I had opened several similar cavities, though smaller, but had overlooked the gall-stones, they being very small, some not larger than a pin-head—all very black, the slightest scratch being sufficient to reveal the bright yellow colour. Continuing the incision, I found, as it approached the portæ, these bodies became larger and more numerous; two (and in one instance three) being found in a sac. Each of the three was as large, if not larger, than a pea. The largest met with was about three-fourths of an inch in transverse, and one and three-fourths in longitudinal diameter. It was firmly imbedded in the substance of the liver, filling up completely the portion of duct in which it was situated, and extending into two branches, which, at that point, united to form one. There were all gradations of size, from this to the small ones mentioned.

No gall-stones could be found in any part of the left lobe, though they might be found in all parts of the right.

The smaller gall-stones were uniformly constituted throughout, excepting a more porous texture in the centre. The largest one, (which I have preserved,) consists of a central nucleus, with several concentric layers of deposite, marked by a shade of variation in the colour. Its internal texture was not so bright as in the smaller ones.

The gall-bladder was *entirely empty*, and of a *blanched* appearance.

FOREIGN CORRESPONDENCE.

LETTER II.

[We publish the following extract, descriptive of an interesting affection, from the letter of a correspondent in Paris.]

* * * * * Dr. LABONE, interne to M. JOBERT, at St. Louis, has lately published some account of a disease of the uterus, to which M. J. has given the name of *dropsy of the neck*, and which he believes has not yet been described by authors. M. J. has, during the present season, frequently called the attention of the class to this form of affection. It occurs generally in lymphatic women, who have never borne children, and whose menstruation has been irregular and scanty. Without affecting materially the general health, this affection sometimes produces sympathetic phenomena, which may induce the suspicion of some serious disease of the uterus. The symptoms are only determined by compression. On examination, the os tincæ is hardly visible; the neck is larger than natural, and uniformly developed as in hypertrophy. At an early stage of the malady. a little prominence is visible at the orifice of the neck, but this disappears with the increase of volume of the neck which ensues. The surface of the neck is natural, except in the colour of the mucous membrane, which is rather pale, as if the blood had been pressed out. Where ulcerations exist, they are to be regarded as complications. On touching the neck of the womb, you do not find it hard, as its aspect would lead you to believe. The tissue offers but little resistance, and gives the feeling of fluctuation. An examination by the rectum enables you to judge less well of the consistence of the neck, but you readily discover its abnormal developement. If there be no ulceration, there is no purulent discharge. If you cautiously introduce a female catheter into the uterine orifice, a large quantity of a white or yellowish, clear, stringy liquid escapes, and the neck diminishes immediately in size. Sometimes this is discharged spontaneously, and instant relief is afforded.

The phenomena which this accumulation of fluid causes can be readily imagined. All the symptoms of hypertrophy of the uterus sometimes occur; and the disease is often confounded with it. A woman in M. Jobert's wards, suffering from this affection, had, previously to her entrance, been several months ineffectually subjected to treatment, for a supposed hypertrophy. It may be distinguished from hypertrophy,—1st. By the presence of the little tubercle which exists at the orifice of the neck, until it has acquired considerable developement. 2d. By the sense of fluctuation it gives on touching it. 3d. By the flow of liquid following the introduction of a catheter. The flow of the menses brings invariable relief. This fact is readily explained. The menstrual fluid, in flowing, necessarily carries with it the whole, or a portion of the liquid accumulated in the uterine cavity. M. Jobert thinks that the cause of the affection may be attributed to the anormal distention and increased secretions of the follicles we encounter about the neck of the uterus, and which become dilated in the same manner as the sebaceous follicles of the skin.

A Board of Naval Surgeons assembled at the Naval Hospital (Asylum) Philadelphia, composed of THOMAS DILLARD, (President,) W. S. W. RUSCHENBERGER, SAMUEL BARRINGTON, WM. MAXWELL WOOD and DANIEL EGBERT, (Members,) for the examina-

tion of Assistant Surgeons for promotion, adjourned on Friday, the 3d of March.

The following is a list of the successful candidates, with the date of their respective commissions, and the subjects of their theses before the Board, arranged in the order of merit.

	Date of Com.	*Subject of Thesis.*
James C. Palmer,	Mar. 26, 1834,	Diseases of the Liver.
John L. Fox,	Feb. 9, 1837,	Medical Topography, and diseases of the Fejee Islands.
Charles F. Guillou,	Do.	Gonorrhœa.
John T. Mason,	Sept. 6, 1837,	Bloodletting, its uses and abuses in the practice of medicine.
Charles D. Maxwell,	Do.	Rheumatism.
Edward J. Rutter,	Do.	Effects upon the functions of the brain produced by external injuries.
John J. Abernethy,	Do.	Fractures of the Femur.
James Malcolm Smith,	Do.	Dislocations of the Femur.
Charles Wm. Tait,	Do.	The best means of preserving the health of Seamen.

It will be observed that all the above named candidates have been six years, and one of them nearly nine years in the Navy.

The subject of the thesis is assigned by the Board; and it is immediately written by the candidate in an adjoining apartment. A single sheet of foolscap paper is given to each, so that the opportunity of copying is cut off; nothing but previous knowledge, and a well trained habit of thought, will enable the candidate to produce a reasonably respectable treatise, written under these difficulties and disadvantages.

CLINICAL LECTURES AND REPORTS.

JEFFERSON MEDICAL COLLEGE.

CLINIC OF PROFESSOR MÜTTER.

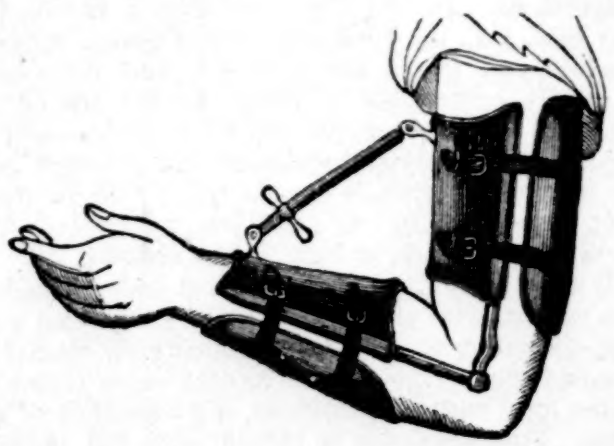
Dispensary of Jefferson Medical College, Jan. 18, 1843.

(Reported by H. T. Child.)

LECTURE III.

CASE.—*False ankylosis of the elbow joint succeeding fracture of the condyles of the humerus, of three months standing, and materially impairing the usefulness of the whole limb—Treated with the screw of Stromeyer.*—The patient, a boy æt. ten years, received a fracture of the condyles of the left arm about four months since and was subjected at that time to the usual treatment for this injury, by the gentleman under whose charge he was placed. The bones united with some deformity, though not a great deal, and the integrity of the joint itself was well preserved. The natural motions in every direction, except *extension*, could be exerted but it was impossible to straighten the limb;—the forearm was flexed at nearly a right angle, and when an attempt was made to diminish the angle, the contraction of the biceps and brachialis internus muscles resisted the effort so completely that scarcely any alteration in the shape of the limb could be effected. There was no pain in the joint even when it was forcibly twisted and the bones pressed against each other, nor was there any swelling or deposite of callus to interfere with the motions, or contraindicate an immediate treatment of the case. The resistance to be overcome was seated in the tendons of the biceps and brachialis internus muscles, which were thrown into bold relief and became rigid whenever an attempt was made to straighten the limb.

This case, Professor M. remarked, would be a very tempting one, for those who resort to the knife on all occasions and at all hazards—and the tendons of the muscles in fault would be at once divided. But he wished the class to recollect what he had so often impressed upon them, that an operation, it matters not how trifling its nature, should always be considered the last resource of the surgeon, and ought never to be performed until all other means calculated to accomplish our end had failed, or unless, from the nature of the case, we could say that nothing but the knife would benefit the patient. In the present instance the operation would be very simple, but it would be painful and might result in serious consequences, and from the short duration of the contraction the tendons were not too rigid to resist *mechanical* means alone. He should, therefore, employ the treatment which he had used for some years in the management of such cases, which consisted in the application of an instrument (a modification of the screw of Stromeyer,) so constructed as to keep up gradual extension of the limb. Should this fail, he might then divide the tendons by passing a small knife between them and the integuments and cutting from without towards the joint, removing the difficulty at once. The instrument was then applied, and the screw turned until the child complained of the extension. (*See fig.*) The screw is to be turn



ed daily a thread or two, until the limb is straightened and then its action must be reversed, the arm being gradually brought back to its first position; after this the limb must be alternately extended and flexed several times a day. By doing this and at the same time making use of the warm bath, friction with oleaginous mixtures, and covering the parts with oiled silk, we secure free motion to the joint, and accomplish a perfect cure. Professor M. next proceeded to make some remarks on ankylosis.

The term ankylosis is derived from the Greek word *αγκυλος*, signifying *bent* or *crooked*, and is employed to designate that condition of a joint in which its motions both active and passive are either partially or entirely destroyed, accompanying which loss there is usually a change in the natural shape of the part. It must be borne in mind, however, that often in ankylosis there is little or no alteration of the shape of the joint involved; it is neither *bent* nor *crooked* as the etymology of the term would indicate. The beautiful specimens of ankylosed hip, elbow and knee joints, contained in my collection, and to which your attention has already been directed on another occasion, prove this fact. As the stiffness may involve one joint or several, may depend on different conditions of the constituents of the part, and may

also be either partial or complete, surgeons have divided this disease into several kinds.

When the stiffness is confined to but one articulation, and is dependent, as it usually is, on the influence of some local cause, the ankylosis is termed *partial* or *local*. When all or nearly all the joints are involved, as in the cases of Baron Percy, Bernard Conner, and others reported in the different surgical works, and the defect is the result of an internal or constitutional cause, it is called *general* or *universal ankylosis*.

Another division of ankylosis is based upon the degree of motion preserved, and the character of the tissue in which the resistance to motion resides. Thus, when all motion is lost and the articular facets are united by bone, cartilage, or dense fibrous tissue, we have a case of *true* or *complete ankylosis*. Mayo has divided this form of the disease into the *osseous*, *cartilaginous*, and *mixed*, inasmuch as either *bone* or *cartilage*, or *both together*, may form the uniting medium.

When the stiffness is dependent upon some defect of the soft tissues of the joint, either *extra capsular* or *intra capsular*, or of the *capsule* itself, and the joint is susceptible of slight motion at the time our examination is made, or, if this be absent, capable of being rendered moveable by proper subsequent management, the ankylosis is *false* or *incomplete*. Again, these false ankyloses may be divided into the *extra capsular*, *intra capsular*, and *capsular*, and this division, so far as prognosis is concerned, is one of much importance. In the first, the tissues surrounding the joint, viz., integuments, cellular tissue, muscles, tendons and fascia are involved, and the case is generally susceptible of cure. In the second and third the rigidity is occasioned by some lesion of the ligaments or synovial membrane, and although curable if taken in time, is exceedingly prone to terminate in incurable or true ankylosis, by involving the cartilages or bones, or both, in the disease.

It must be obvious that the defect under consideration cannot, with strict propriety, be considered a *disease*, it is rather a product or termination of morbid action, and often on this account its occurrence proves one of the most certain indications of a cessation of disease. True ankylosis is indeed often the only favourable result in certain affections of the joints, and we consider the case as *cured* when by our remedies we are able to bring about its occurrence.

Before undertaking to relieve a stiff joint, therefore, we must carefully investigate its causes, and ascertain whether or not it is proper to attempt a cure of the deformity to which it often gives rise.

Causes.—The causes which operate in the production of ankylosis are numerous, and most of them occasion the complaint by keeping the parts involved motionless, or nearly so, for a length of time. There are some, however, that seem to exert their influence under all circumstances; for example, *old age*, *chronic rheumatism* and *chronic gout*. It is true the joints usually involved from the operation of any one of these causes are those possessing comparatively but little motion, as those of the spine, pelvis, and some of the ginglymoidal; and the individuals themselves are forced to lead very sedentary lives, which will of course favour the occurrence of stiffness.

True ankylosis is also occasionally developed in the effort which nature makes to protect herself from harm in certain curvatures of the spinal column. This beautiful provision is well shown in several specimens in my collection taken from individuals affected with this complaint. Ledges of bone are thrown out in the hollow of the different curves, so that the spinal column is supported and prevented from yielding so far as to endanger life.

True ankylosis is, however, most generally the result of some disease of the synovial membranes, cartilages, or bones of a joint, although it may result from long confinement to one position, as has been clearly shown by Malgaigne, Teissier, and others. It is commonly believed that the ankylosis resulting from long confinement of a joint to one position, as in the treatment of fractures of the extremities, belongs to the class of incomplete or false; and this to a certain extent is true, but we often have produced instead complete and incurable stiffness. This fact adds another to the long list of objections to the use of an *immoveable* apparatus, in the treatment of fractures.

False ankylosis, especially the extra capsular form, is developed by causes somewhat similar, although they produce lesions by no means so grave as those which are present in the true. The most common of all these causes is *rest*. When a joint, even although perfectly healthy, is confined to one position for any length of time, we find its integuments and the cellular tissue beneath them, contract and become more or less rigid; its ligaments and tendons also stiffen, and the muscles to which they are attached shorten, where the limb is flexed, and lengthen, when it is extended, and often undergo changes in their tissue, by which they lose their physical characteristics, and are rendered to a certain extent useless, while the synovial secretion is arrested or diminished. A good illustration of the influence of rest upon the joints is afforded by the stiffened limbs of the *Fakirs* of India, who actuated by religious motives condemn themselves to the observance of one position during their whole lives. The same thing is often seen after the treatment of fractures, luxations, or sprains, where the limb has been maintained in one position for too long a period.

Wounds followed by sloughing of the skin, burns, scalds, &c., in short, any injury likely to be followed by extensive cicatrization, may lay the foundation of extra-capsular ankylosis. You all know the power with which one of these cicatrices forms, often destroying or displacing some of the most important parts of the body. Here is a hand the fingers of which nearly touch the back of the forearm in consequence of a burn. This drawing you recollect as the one taken from a patient whose chin was drawn down to the sternum by the cicatrix of a burn, and held there for twenty-seven years. Such cases can only be relieved by very extensive plastic operations.

Extra-capsular ankylosis is also sometimes brought on by the developement of an ulcer, or an abscess, or a phlebitis, or an angioleucitis, the result of some trivial wound or blow received upon the part. The complaint being generally confined to one side of the limb, there is contraction in this direction produced partly by the patient's flexing the limb to take off pressure from the inflamed surface, and partly by the swelling itself displacing the tendons and fascia in the neighbourhood. By and by lymph is deposited, and unless the disease is cured, there remains permanent contraction of the limb, with motion in but one direction. This form is readily distinguished from that dependent upon shortening of the muscles by the following experiment. If we take hold of the limb farthest removed from the body and steady the one to which it is attached, and then attempt to separate them, or bring the member to its proper shape, we find in this form of ankylosis that the soft parts, although rigid and unyielding, are

smooth and *even* upon the surface. Now when the tendons or muscles are chiefly in fault, as in the case before us, and the same experiment is tried, we find them standing out in bold relief, as hard and as rigid as pieces of wire, while the soft parts in the vicinity are comparatively loose and yielding.

Different affections of the tendons or muscles, in the vicinity of a joint, may also cause extra-capsular ankylosis. A man, for example, receives a slight wound of a tendon or muscle; irritation or even inflammation of the part sets in, and the joint contracts by a shortening of the muscle alone. Sometimes the same cause may excite adhesions between the tendon and its sheath, or may even cause a sloughing of the same part.

Sometimes this form of ankylosis is dependent on a constitutional cause, as rheumatism or gout: and the boy presented to you the other day with telapes equinus from rheumatism, both of whose ankles were immoveable, was an instance of this kind. Often, too, a loss of muscular power, either by sloughing, or wounds, or paralysis on one side of the joint, by destroying, as it does, the balance of power which naturally exists, will bring on this form of ankylosis. The sound muscles being no longer opposed by their antagonists, pull the limb into an unnatural position; and as there is no power to overcome this influence, they keep it contracted, and gradually accommodate themselves in length to the altered condition of the parts, so that when we attempt to straighten the member we find it impossible to do so, until, by stretching or division with the knife, the shortened muscles are made to yield.

In certain forms of club-foot, torticollis, contraction of the fingers and toes, &c., this kind of ankylosis is encountered. In cases of long standing we invariably find the muscles and tendons of the weak side stretched and frayed out, and so much weakened that months and even years may elapse before they regain their natural tone and vigor. This should always be explained to the patient, who will be obliged to make use of artificial support for some time after the member has been restored to its natural shape.

Extra-capsular ankylosis is also the result of contraction of fascia, as we see in certain forms of contracted elbow, knee, and hands. It may also proceed from the growth of tumors, and the deposite of bone around the joint.

Capsular Ankylosis.—This form is generally the result of a severe strain or twist of a joint, in consequence of which the capsular ligament is more or less injured—a luxation or fracture near the joint, gout, rheumatism, wounds, and even rest may occasion the same thing. It is extremely difficult to distinguish this variety of ankylosis from the *intra-capsular;* but usually in the latter the cause operating is more violent, the stiffness is accompanied with more pain, and it is more difficult to move the joint. When a capsular ankylosis is examined by dissection, we find the fibrous tissue of the capsule thickened and hardened, and sometimes converted here and there into cartilage or bone.

Intra-Capsular Ankylosis is the result of some disease of the synovial membrane, usually acute or chronic inflammation, or their results; but the peculiar degeneration of this tissue, so well described by Sir Benjamin Brodie, may also lay the foundation of this complaint. The bond of union here is nothing more than organized coagulable lymph, which sometimes stretches across the joint from bone to bone, in bands or cords; at others it is deposited in patches, and, in a few rare instances, has been found spread over nearly the whole of the articulating surfaces of the joint—thus glueing the bones, as it were, to each other.

The history of the case will generally enable us to decide as to the precise nature of the bond of union; but it should always be borne in mind that synovitis may lay the foundation of capsular, or even extra-capsular ankylosis, producing, as it often does, sub-inflammation of the cellular and fibrous tissues about the joint, and also the peculiar contraction of the muscles and tendons usually met with in diseases of the articulations. It also frequently gives rise to true ankylosis—the disease extending to the cartilage and bones. The extreme rigidity of the joint, the apparent soundness of the tissues around it, the swelling which, in the first stage of the disease, is usually present, the pain excited by moving the articulation, or pushing one bone against the other, the character of the cause, and the fact that such cases are usually preceded by all the symptoms of inflammation of the synovial membranes, all serve to indicate to us the variety of the affection.

Liability.—It is usually stated that the ginglimoid articulations are more liable than the orbicular to both true and false ankylosis; and the observation is correct, owing chiefly to the circumstance that the former are more exposed to accidents. Their large articulating surfaces, and the number of tendons and fascia by which they are surrounded, also predispose to the occurrence of the disease.

Diagnosis.—There is scarcely any difficulty in distinguishing the different forms of ankylosis from other complaints, but it often demands a great deal of tact to distinguish them from each other. False ankylosis, for example, may exist, and yet the joint be as immoveable as in the true variety; but by careful examination we may generally arrive at a just diagnosis. If, for example, there is no motion in the joint, when it is twisted or turned with great force, if these efforts excite no pain, if the stiffness has been preceded by extensive intra-capsular disease, if the joint is comparatively but little swollen, if the patient feels a jarring when the limb is struck, or when he takes a false step, if it be in the leg, if he dreads these shocks, and finally, if, when we attempt either to bend or straighten the limb, the muscles and tendons about it are scarcely moved, we may pretty safely conclude that we have a case of true ankylosis to contend with. False ankylosis is also sometimes confounded with a rigid condition of the muscles surrounding a joint, which suffers from some acute or chronic inflammatory disease. A case of this kind was recently shown me by my friend Dr. Rodman, and it occurred in the son of Mr. B——, of Schuylkill Eighth street. This lad had suffered from coxalgia for some months, and his limb was shortened seven inches—the thigh flexed at a right angle with the pelvis, and no perceptible motion in the hip-joint. At first I was under the impression that true ankylosis had taken place, but on a more careful examination it struck me that it might possibly be a case of simple false ankylosis from rigid muscles. I therefore applied an apparatus by which moderate and constant extension of the limb might be kept up, and had the satisfaction to find that in the course of a few days, without pain, fever, or any inconvenience, the limb was reduced to the plane of its fellow, and within one inch of its natural length. The details of this case will be given on another occasion. The fact that this condition of the muscles may give rise to complete immobility should be constantly borne in mind in our examination of stiffened joints.

In forming a diagnosis between the different kinds

of false ankylosis, we must take into consideration the history of the case. If the rigidity is the result of *rest*, *cicatrices*, affections of the *subcutaneous cellular tissue*, *spasm* of the *muscles*, *slight wounds of the tendons*, or *injury of the fascia*, it is probably *extra-capsular*. If caused by a *sprain*, or *punctured wound*, or a *blow*, it is *capsular*; and finally, if *acute* or *chronic synovitis*, or *gout*, or *rheumatism*, or *slight disease* of the *cartilages* or *bones* has existed, we shall have the *intra-capsular* form.

Prognosis.—The prognosis in this affection varies with the character of the lesion, whether it be true or false; and if false, the nature of its cause, the duration of the case, the age and health of the patient, and the joint involved.

The prognosis, as regards a cure, is always most unfavourable in true ankylosis; and, until very recently—indeed, until the publication on this subject by my friend Dr. J. Rhea Barton, of Philadelphia,—all such cases were ranked among the incurable forms of the affection; and even now the propriety of resorting to the operation of Dr. Barton must be the result of mature deliberation. Many cases give rise to so little inconvenience as scarcely to warrant the hazard of the remedy; while others, as those which result from caries, or extensive disease of a joint, should not, as a general rule, be touched, inasmuch as ankylosis is the most favourable termination of the disease; besides which, the operation may excite anew a disease in the part sufficiently intense to destroy the patient. When the stiffness is partial, the prognosis is usually more favourable, but even here we sometimes find it impossible to effect a cure. When it is dependent upon extra-capsular lesion, of no very long standing, and there is no loss of tendon or muscle by sloughing, the prognosis is favourable; but if the ankylosis be capsular or intra-capsular, unless the primary disease has been slight, or confined to the ligamentous tissue, as in gout or rheumatism, and the case of recent occurrence, we shall generally have great difficulty in accomplishing our object.

When the stiffness depends on the location of a tumour, &c. in the vicinity of a joint, the prognosis is generally favourable, inasmuch as we can remove the cause. The younger the person, the greater the probability of a cure in almost all cases; for, as we increase in years, the tissues become more rigid and unyielding. The general health, too, of the patient must be taken into consideration; there are some persons so irritable and prone to inflammation, that the slightest effort towards a cure, made either with the knife or mechanical means alone, is sure to excite disease. We should, therefore, carefully examine the case, and determine, as nearly as possible, the propriety of instituting any treatment before our attempts are commenced. In illustration of the importance of this cure, I may mention that several persons have either lost their lives, or been reduced to a very critical condition, by the attempts to cure false ankylosis by the screw. Prof. Pancoast mentioned to me a few days since, that he had been told of three individuals who had thus been destroyed. In my own practice I have been obliged, in two cases, to suspend the treatment, until the general health was so much improved as to justify the attempt to straighten the limb to be renewed. The prognosis is also modified by the joint involved; for we find it much more easy, as a general rule, to cure ankylosis of the *orbicular*, than of the *ginglymoidal* articulations. The function of the joint is also found to modify the prospects of cure: thus, where the articulations of the maxillary bones are involved, as in the cases of Cruveilhier and others, it will be f impossible, by any operation, to afford relief, one case mentioned by Blackburn, the patient from inanition in consequence of this cause.

(To be continued.)

BIBLIOGRAPHICAL NOTICE.

Valedictory Address delivered before the Graduate Pennsylvania Medical College; Session of 184 By Robert M. Bird, M. D., Professor of Ma Medica, and Institutes of Medicine. Philadel 1843. 8vo. pp. 12.

This is a short, well written address; presenting, h ever, we think, too disheartening a picture of the a condition of the physician in this country. Prof. B thinks medicine has only "reached the point in w it is allowed to *be respectable*." Might he not h added *honourable?* That it is not profitable we agree with him, and that the general influence o profession is not such as the amount of intelligence moral worth it contains entitle it to, must, we fea acknowledged. This Dr. Bird attributes to the stan of scientific attainment not being sufficiently ele and the evil, he thinks, is due to the faulty syste medical education pursued throughout the country. preliminary examination being required of those are about entering on the study of medicine, the consequently no evidence of qualification for the s course of study to be commenced. The short of the required term of study is another drawback,— period being "too short for any but very active, dili and well disciplined minds, to travel through the circle of the Medical Sciences." The private and h method of examination Dr. B. conceives is also disa tageous.

"The general evil of this system is, its ma access to the profession so easy as to seduce m persons to enter, or attempt to enter it, who are titute of all the requisites essential to the forma of a true medical character; and the profession is sulted by the prevailing idea that any body may made a physician. This is a very fatal error; it drives to the threshold of medicine many im petent persons,—incompetent from want of ed tion and want of talent,—among whom it would wonderful if some were not permitted to enter. drives many, even, who have not complied with moderate requisitions of the established sys The American colleges call only for three y of study; a term which students and their fr sometimes presume to consider superfluously l They require that this period of study should be p ed in the office of a respectable physician,— merely that the student may be directed in his r ing by an instructor, but that he may be carri the bedside of the sick, in order to be made practi ly acquainted with disease, and with the d which he will soon be called on to perform: and it has happened that students have even reg this requisition as useless, and presented themse as candidates for graduation, without complying it—as if books and lectures *alone* could make p physicians,—as if this requisition, always cons ed a most important one, were made only in and never meant to be enforced. In fact, medi

seems to be regarded as a very good sort of business, easily entered, and perfectly well adapted to those who are not well qualified for any other.

"The admission of such incompetent persons, sometimes effected by accident, by error, by false humanity,—perhaps, in some quarters, by a want of regard for the solemn obligations incurred by those who grant medical degrees—is productive of various ill consequences by which the community suffers, and the profession is depreciated. It is to the introduction of individuals not of the highest tone of manners and feeling, that we owe so many of the petty quarrels, the mean jealousies, the tricks of rivalry and hostility, for which the profession is ridiculed; while baser spirits, imitating the examples of successful quackery, by which we are continually surrounded and *they* seduced, appear, by their own degradation, to sink the whole profession down to the level of their wretched rivals."

Another cause which has apparently escaped our author's attention, and whose influence is by no means insignificant, is individual ambition, and its necessary consequence, the multiplication of schools and teachers, with inordinate and destructive competition; thus flinging open the portals of the profession to all who choose to enter—quantity, not quality being looked to. In all the medical schools within the sphere of our immediate observation there has been a steady progressive improvement in the system of medical education, within the past few years. The facilities and opportunities for instruction are much greater than they were even three or four years since, and there is a general disposition among students—at least those visiting our city—to avail themselves fully of them.

We trust the gloomy anticipations of our author, which we confess we cannot share, will not be realized; that our profession will continue to be *respectable;* and that its high claims will be practically as well as abstractedly confessed, at least in this country.

Academy of Medicine, Paris.

SYPHILITIC ERUPTIONS.

M. Jolly presented a report on a memoir by M. Gibert, on syphilitic eruptions.

The question proposed by the author is—are these diseases always secondary? Are they never primary? To answer it he examines all the doctrines and facts recorded on the subject, and concludes that syphylitic diseases of the skin are invariably, the consequence of a primary venereal infection.

Having combatted the ideas of M. Ricord, with respect to inoculation, the author proceeds to describe syphilitic eruptions, which he divides into eight species, distinguished by their external characters.

M. Gibert recommends a constitutional treatment, and gives a preference to mercurial preparations, in favour of which the best authorities are united.

In answer to the objections of M. Gibert, respecting inoculation, M. Ricord observed that he was about to present the academy an interesting preparation, but would first allude to a subject which so nearly interested him. To prevent repetition he would enounce the following propositions:—

No secondary symptoms, and consequently no syphilitic diseases of the skin, can occur without having been preceded by chancre.

If, to admit the existence of chancre, we require the presence of a certain number of external appearances—the characters denominated *Hunterian*—there is an end to all science on the subject. The specific character of chancre does not exist in the form, color, base of the ulcer, &c., but in the nature of the pus, which it secretes, and which may be determined by inoculation.

On the other hand, if the existence of chancres is to be denied unless the ulcer be seen, we are compelled to deny the possibility of their existence in situations where the eye cannot penetrate; in the urethra, for example, and in the vagina or neck of the uterus, before M. Ricord succeeded in introducing the use of the speculm as a means of diagnosis in these disorders. It must be remarked, that the occurrence of chancre of the urethra is rare in proportion to the distance of the part attacked from the meatus urinarius. The question of the bubo *d'emblée* which, at first sight, seemed to contradict the doctrine of M. Ricord, only confirms it.

This species of bubo never contains pus capable of being inoculated; or, if the pus be of this nature, it will be found that the bubo was always preceded by chancre, either apparent or masked. An interesting fact recently occurred confirmatory of this assertion. An *interne* of the Venereal Hospital had a bubo which he thought to be one of this species, and as the pus discharged by it was not inoculable, he considered the fact irreconcilable with M. Ricord's theory. On examining the urethra, however, carefully, he found a deep-seated chancre within the orifice of the urethra.

After these few remarks M. Ricord showed the preparation already alluded to. It was taken from a patient at the Venereal Hospital, who laboured under a gonorrhœa which resisted every species of treatment. A fistulous abscess opened in the perineum. The patient was afterwards attacked by the phthisis and died. The lungs were filled with tubercles, and the whole of the canal of the urethra contained numerous ulcers of a tubercular nature. The prostate gland, also, contained a great number of tubercles.—*Lond. Prov. Med. Journ.* Jan. 14.

GREEN CATARACT.

M. H. Cunier, in a report of the diseases treated at the Ophthalmic Dispensary of Brussels, invites attention to this form of cataract, which is often confounded with glaucoma, and the unfortunate patients thus abandoned to darkness. Dr. C. says, that he has met with eight cases of this kind. The individuals laboured under green cataract, which had been mistaken for incurable glaucoma. Seven of these patients were operated on and restored to sight.—*Ibid, from L'Examinateur Medical.*

New Method of Administering Quinine.
By Dr. GUASTAMACCHIA.

The author's object was to find some method of avoiding the disgust which the bitterness of quinine always excites; and after repeated trials, he says he found it best to dissolve eight grains of the sulphate in half an ounce of rectified spirit, and rub it, in two doses, with an interval of a quarter of an hour between them, along the spine. In intermittent fever this should be done at the beginning of the cold fit; and it very often prevented even a single recurrence of it.—*Brit. and For. Med. Rev. from Il Filiatre Sebezio.* Aug. 1841.

RETROSPECT OF THE MEDICAL SCIENCES.

FALSE JALAP.

At a meeting of the Philadelphia College of Pharmacy, held January 2, 1843, Mr. AUGUSTINE DUHAMEL submitted the Report of the Committee appointed to investigate a certain article of false jalap, brought from New York.

"Upon examination, it was found to be made up of the following pieces:

1st. A large spindle-shaped dried root, or rather tuber, flattened on one side, about six inches long and three wide, weighing six ounces.

2d. The larger half of a similar tuber, transversely cut, forming a segment four inches in its largest diameter, weighing three and a half ounces.

3d and 4th. Two entire tubers, smaller in size, ovate, one of them kidney-form and pointed, weighing together about five ounces.

A further description of this article is comprised under the following general features:

It is light in weight compared with jalap; externally very rugose, not minutely so, like the jalap, but coarsely furrowed: it is of a light brown color, with dark shades of black occupying the cavities, through which are interspersed minute shining black specks. Its fracture is rough and uneven, and its interior surface presents a uniform, grayish-white, ligneous appearance, and somewhat loose texture, marked by ash-colored concentric circles, composed of a harder and more compact substance indicating resin. One of the smaller tubers, wanting this distinguishing character, appears purely farinaceous. The taste and smell of these different tubers are feeble, sweetish, peculiar, and closely associated, though very distinct from jalap.

The largest root, divided transversely with a saw, exhibits vertical cavities, proceeding from incisions made through the whole length of the exterior surface to facilitate drying. In No. 2 the incisions are perceptible, but it has no holes like the other. Although a slight disparity exists in the internal appearance of these several tubers, yet their identity, in point of taste and smell, conclusively proves them to be of a common origin. The powder is grayish-white, and does not excite coughing or sneezing during pulverization.

This *drug* was represented to your Committee as coming from Mexico. A considerable quantity of it is to be found in the house of a drug broker in New York, who offers it for sale as *overgrown jalap root*, at a price little inferior to that which the genuine commands.

Your Committee are at a loss to determine from what plant it derives its source, as it bears no very close resemblance to the various adulterations to which jalap, as found in commerce, is known to be subject. It bears no analogy with the different specimens contained in the cabinets of our Professors of Materia Medica. Diligent inquiry among our druggists, (to whom it appeared novel,) led to no more satisfactory acquaintance with it, from which no doubt is left upon the minds of your Committee that the present is its first introduction into an American market.

It is evidently the produce of a *Convolvulus*, but of what particular species it is dfficult to say. It does not respond to the description of the dried root of the *C. panduratus*, nor any of the known falsifications furnished by this genus. The same observation applies to two varieties of adulterations mentioned by Guibourt in his *Histoire des Drogues.*

Contrasted with the well known characters of officinal jalap, (*Ipomœa jalapa*,) it presents the following discrepancies:

It is larger, lighter in comparison, wants brittleness, shining fracture and compactness, acridity of taste, odor, and color. It is also deficient in resin, and wants the striated and reticulated appearance of exterior which the other possesses.

In order to ascertain how its chemical relations would comport with jalap, a number of experiments were conducted by the Chairman of your Committee, the result of which enables them to furnish a proximate analysis of its composition as follows. In juxtaposition are placed the analyses of officinal and male jalaps.

False Jalap.

Resin, consisting of 15 soft and 20 of dry brittle resin,	35.
Gummous Extract,	85.
Starch mixed with Inulin,	140.
Lignin,	116.
Albumen and Gum,	50.
Saccharine Matter, Salts of Lime, and loss,	74.
	500

Analyses from 500 parts.

Of Jalap, by Cadet.		*Of Male Jalap. by Ledanois.*	
Resin,	50	Resin,	40
Gummy Extract,	220	Gummy Extract,	128
Fecula,	2	Fecula,	16
Lignin,	145	Lignin,	290
Albumen,	12	Albumen,	12

Having proceeded thus far, it remained for yonr Committee to ascertain its medicinal properties, if, after what is here related, it could be supposed to possess any. This they were enabled to do through the courteous offer of Prof. Dunglison. A trial of its virtues was made at the Blockley Hospital, under the inspection of some of the resident faculty, upon six different individuals, in doses of fifteen to twenty grains, without obtaining any effect whatever."—*American Journal of Pharmacy*, Jan., 1843.

Taliacotian Operation. By J. MASON WARREN, M. D. of Boston.

The patient was a lady, 30 years old. Having a little warty excrescence on the nose, she applied to a quack, who happened to enjoy considerable notoriety at the time in the treatment of cancers, and who, as usual, at once informed her that the disease was cancerous, and advised its removal. A caustic was applied, but so badly managed, that not only the disease, but a portion of the nose also was destroyed, leaving the unfortunate subject in a most distressing situation.

It may, perhaps, be remembered, that in a former case, which was published in this Journal, an operation was required under precisely similar circumstances; and they may serve as a warning to those who are so led away as to submit themselves to the mercy of ignorant charlatans.

This lady, when I first saw her, some time after the ulceration from the effects of the caustic had healed, looked exactly as if the nose had been neatly ex-

cised; the skin, a portion of the cartilage forming the septum nasi, and about one-third of the columna were wanting. The nasal cavities were thus quite exposed, and the deformity produced of a very striking and disagreeable character.

I at once perceived that the Indian method would not be applicable, as it required too great a sacrifice in bringing the integument from the forehead, and I determined to adopt the Italian method of transplanting the skin from another part of the body. In a former case, already referred to, where the skin was taken from the fore-arm near the wrist, an obstacle presented itself, which had not been fully foreseen; this was the impossibility of retaining the arm sufficiently steady, by any apparatus that could be devised, to prevent the movements of the body being communicated to the part where the uniting process was going on; by the method of Taliacotius, the head and arm are kept immoveably confined during the time of union, and no motion of the patient can disturb these parts if the bandage remains firm. This position may easily be supported by a thin subject, but in a large muscular man it is next to impossible even to bring the arm into the proper position, much less to preserve it there for any length of time. The present case being considered a proper one for the latter method, it was determined to attempt it.

I advised my patient to return home, and to have a bandage made such as described and depicted in the work of Taliacotius, and to exercise herself daily for a few weeks in keeping the arm up in contact with the face in the position which it would be requisite to maintain after the operation. This was done, and all preparations being made, the operation was performed on the 21st of October, 1840, in the presence of Dr. Reynolds, Dr. Townsend, Dr. Inches, and a number of other medical gentlemen.

The cicatrix covering the edge of the nostrils was first removed, and the apex of the septum and columna nasi made into a raw surface. A flap, nearly double the size required, was now dissected out from over the upper part of the biceps muscle of the right arm, its base, which presented downwards, being left attached. The bleeding having ceased, and the flap contracted, which it did nearly one-half, the arm was brought up to the face. and the edges of the flap confined in contact with the raw surface of the nose by six sutures. The bandage of Taliacotius was now applied, and served to maintain the arm immoveably fixed in contact with the head. The whole of this painful operation was supported with the most determined fortitude.

October 22d.—Since yesterday she has remained in an arm-chair, preferring the sitting posture as the most comfortable, both for breathing and for taking nourishment. For an hour or two after the operation, the arm was quite numb from its constrained position and the pressure of the bandages; this gradually changed to a painful sensation. She now has some pain in the elbow, none in the shoulder, where it would have been most expected, and less than yesterday in the fore arm. Her pulse is good, she has slept at intervals, and takes gruel with appetite, sucking it through a glass milk tube, which was the best contrivance we could think of for this purpose; she has left her chair and walked about the room without disturbing the bandages.

23d.—She complains to day of severe pain in the wrist, which was very soon relieved by wetting the bandages with laudanum; and almost immediately after each application, when it was required during the day, she was composed to sleep. The bandages were relaxed a little from being wet, but not so much as to injure the adhesion.

24th.—At 10 o'clock, 72 hours after the operation, I proceeded, in presence of a number of medical gentlemen, to divide the pedicle, and release the arm from its painful position. On first letting it down, the arm appeared quite paralyzed, but by gentle friction the power of motion and sensation was gradually restored.

A perfect adhesion had taken place between the new flap and the right side of the nose. On the other side, the skin was so wrinkled up, from the pressure of the head downwards on the arm, that it was not possible to determine what was the state of union. Out of the new flap a pedicle was now shaped, to serve for the completion of the columna, and was confined in contact with what remained of the old one, by a single suture.

The patient was in good spirits, and appeared but little fatigued from the painful position in which she had been confined for such a length of time. Her sufferings had certainly been greatly alleviated by the possibility of being able to move about the room without interfering with the adhesive process, owing to the perfect retentive power of the bandages.

25th.—Quite comfortable; the tip of the nose looked well; the edges on one side somewhat livid, but on being touched with the knife bled freely; a portion of the new columna in a sloughing state.

November 11.—A small piece of the skin which formed the septum having sloughed, the remainder has settled down, and at present is firmly united in its situation. The nose has a good shape, but is still a little swollen.

December 12th.—This patient returned home well. Nose has entirely healed; its form is good; the tip is slightly turned up, and the whole organ a little shortened when compared with its original dimensions; but is still agreeable, and presents nothing remarkable to a casual observer; the line of union has so melted down into the surrounding parts as to be scarcely perceptible. She was seen by a number of physicians before leaving town, who were able to congratulate her on the successful termination of the operation.

At the present time more than two years have elapsed, and no unfavorable change has taken place in the aspect of the restored organ, and the patient has had no reason to regret the suffering she has undergone.—*Boston Medical and Surgical Journal*, March 1, 1843.

Observations on a particular Form of Encysted Tumour, which occurs in the Neck, but is not necessarily connected with the Thyroid Body. By Benjamin Phillips, F. R. S., Surgeon to the St. Marylebone Infirmary, &c.

Mr. Phillips describes what Maunoir of Geneva had described before as Hydrocele of the Neck, and has been described also by Mr. Hill, of Dumfries, Dr. O'Beirne, and others. The following is his summary drawn from the cases of all.

"The cases which I have detailed, as well as those described by the authors I have named, justify me in stating, that there is a class of unilocular or multilocular encysted tumors developed in the neck, which contain a serous fluid, varying from a light yellow to a deep coffee-color; that in its nature this fluid is albuminous, coagulable by heat; that those tumors are generally developed, quite independently of the thyroid body, though in their progress they may become intimately connected with it, but that the connection

does not usually involve any change of structure in that organ; that they are most frequently developed at, or after, the middle period of life; that they occur almost indiscriminately in both sexes; that they are almost always of slow growth, and that they often attain a large size; that they do not usually prove troublesome, until they are of sufficient size to interfere with respiration or deglutition. That the treatment by simple puncture, so as to evacuate their contents, is usually insufficient to cure the disease, because the opening is apt to close up and the cavity to refill; that puncture, with injection, has not succeeded better, and for this reason, either the fluid is too stimulating, and produces violent inflammation, with spasmodic action of the organs of respiration and deglutition, or it does not exercise sufficient action to modify the surface of the sac; and it is not easy to ascertain the just medium; that the treatment by making an incision of sufficient extent to expose the greater part of the interior of the sac, and stuffing the cavity, has been followed by too much local and constitutional irritation to render it prudent to adopt it as an ordinary method of cure; that the plan which has succeeded best is that to which Mr. Hill, of Dumfries, resorted, and which has been employed by M. Maunoir, Dr. O'Beirne, and Petrale, namely, puncture and seton. Whether an ordinary tent passed through the long diameter of the sac, after puncture, might not answer the purpose equally well, we have not yet the necessary experience to determine, but I see no reason why it should not succeed."

He relates, himself, two cases. In the first, the cyst discharged itself through a puncture, made with an exploring needle. The fluid, in the first instance, was thin and bloody, then became bright red, and reduced the strength of the patient as well as the size of the tumor. Next the discharge became sero-purulent, and lastly purulent. It stopped under the influence of time, *or* quiet and swallowing ice. The patient recovered, the tumor having lessened very much, but the thyroid body remaining enlarged.

In the second case, the tumor cracked spontaneously, and about three pints of reddish serous fluid escaped. On the following night, three pints more escaped. A sero-purulent discharge flowed for many weeks, when she recovered, an inconsiderable enlargement of the thyroid body remaining. Twelve months afterwards there had been no re-accumulation of fluid in the sac, but the enlargement of the thyroid body still continued, and a small fistulous communication with the sac remained. We fancy that this affection is not very uncommon.—*Med. Chir. Review*, Jan., 1843.

English Physicians. By Prof. Marx.

The English physicians know little of scientific medicine. They are wanting in systems. With them theory has not interpenetrated experience. Anything of the kind they display is no more than an insipid eclecticism. They think little of arrangements and deductions founded on or flowing from fundamental principles. Their science is not the product of pure thought; it is the mosaic work of observations. If subjects of the kind be brought under the notice of an Englishman, he scarcely understands you; and when you try to make him comprehend your meaning, he will say, we must be just before we are generous. They insist that people should busy themselves with substantial realities, and not fine-sounding words. The construction of philosophical theories, and the dressing up and arrangement of facts and general propositions, are certainly not their forte. But it would be matter for regret if they were to fritter away their sound sense, enlightened judgment, and innate truthfulness in an infinity of subtle distinctions; or become mystified by the opinions of the theorizing metaphysical school. But in fact, their native love of freedom repels the stays and straight-waistcoats of a system. Inhabitants of a country which carries on an intercourse with the whole world, they are accustomed to a wide horizon, and from an early period are practised to distinguish the apparent from the real. They think that this is peculiarly the duty of the physician; that he must examine each fact in its varied and almost infinite relations as clearly, accurately, and precisely as possible; and then arrange the results logically, expressing them under plain and perspicuous propositions. Poets only may be permitted to weave the silken threads of imagination, and philosophers plunge into the depths of pure thought to bring up mere idealities, useless fantasies and systems, or wander after cold and desolate generalities. I had already formed opinions of this kind respecting the English physicians, and the tendency of their scientific pursuits, from a perusal of their writings. A personal acquaintance with them at the bed-side, in their public institutions, and in their schools, has only served to fix and extend these opinions.—*British and Foreign Medical Review*, January, 1843.

NERVOUS OPHTHALMIA.

The affection so named by M. Lisfranc is a good example of local *irritation* in contradistinction to an *inflammation*; in other words, perverted action of the nerves, rather than of the blood-vessels of the part. The symptoms are lachrymation; no morbid appearance in the interior of the eye or on the cornea; marked photophobia; the eyelids carefully shut; on opening the eyelids, the patient feels as if points of nails were being driven into the globe; the conjunctiva is slightly reddened, but does not appear swollen. In the treatment, antiphlogistics fail. Extract of belladonna is to be rubbed on the temples and around the base of the orbits night and morning; sometimes the same medicines may be administered internally. In a few days the cure is complete. Finding such irritations of a mucous surface externally, closely simulating the state of inflammation, M. Lisfranc is naturally led to conclude that probably similar conditions and simulations may not unfrequently exist internally; and that many pains in the stomach, bowels, urethra, &c., supposed be inflammatory, and yet resisting all antiphlogistic and revulsive means, may be dependent on mere irritation, and ready to yield almost at once to narcotics. We agree with M. Lisfranc in thinking this extremely probable.—*Ibid.*

New mode of Extraction of Cataract. By Dr. Bonnet, of Lyons.

He lays the patient on his back. If it is the left eye, he places himself at the patient's right side, and having applied the elevator and depressor to the eyelids, entrusts them to two assistants, who must see that they do not press upon the eyeball. With his left hand, the operator holds a common pair of forceps; with his right, a hooked spring pair. With the former, he raises the conjunctiva into a fold, and with the latter takes firm hold of that membrane, and of the subconjunctival fascia about one-sixth of an inch from the cornea, a little above the external angle of the eyelids. This forceps is then entrusted to the assistant who supports the upper eyelid; it fixes the

eye aud prevents it from rolling inwards. The operator now takes the depressor of the lower lid into his left hand, and with the right uses the knife to divide the cornea.

To the mode of fixing the eye, above explained, he ascribes the promptitude, precision, and facility with which the section is accomplished. The incision is always parallel to the edge of the cornea; the iris is never wounded; the operation is as simple, he says, as bleeding: no dangerous consequences ever arise from the pinching of the conjunctive with the forceps; the specula applied to the eyelids prevent pressure on the eyeball, and that dangerous expulsion of vitreous humour which is apt to happen when the fingers are employed to fix the eye and separate the eyelids! All this we owe to the operation for strabismus!

Dr. Pétrequin employs Bonnet's method of fixing the eye, in the operation of displacement, and in those for artificial pupil.—*Ibid, from Annales d'Oculistique.*

On the Chemical Composition of the Fluid of Ranula.
By L. Gmelin.

It is entirely different from saliva, containing no sulphocyanate, and only a small quantity of salivine, but chiefly albumen. The albumen, however, amounts to only 2 per cent., though the fluid is as thick as others containing about 5 per cent. It is to be supposed, therefore, either that the fluid of ranula contains some peculiar material to which it owes its thickness, or else that the albumen in it is of some peculiar kind.—*Ibid, from the Annalen der Chemie*, 1842.

On the Fractures of the Lower End of the Radius.
By M. Voillemier.

The chief object of this very excellent paper is to prove, especially by examination after death, the direction which fractures of this kind usually take, and thence to deduce the best method of treating them. The difficulty and importance of the question is sufficiently proved by the number of essays which have been recently published upon it. We can only abstract the peculiar portions of the author's views.

As the basis of these he points out some facts in the structure of the radius, namely, the double inclination of its inferior articular surface, which is oblique from above downwards and from before backwards, and from within outwards; its prominent border behind and on the outer side; and, above all, the thinness of the compact tissue of the lower extremity of the radius, when compared with that of the shaft, the former becoming suddenly almost as thin as paper, while the latter is so thick that there is scarcely any medullary tube. It is from this last circumstance that there results both the peculiar tendency to fracture near the wrist, and the position in which, according to M. Voillemier, the fragments are usually placed, and which is such that the fracture may be called *fracture by penetration*.

In a fall on the hand (the most frequent cause of this fracture,) all the force of the shock is transmitted to the radius, and it breaks at its weakest point, where the compact tissue is thinnest, and *that* is just above the wrist-joint. At this part, too, the cancellous tissue is first abundant; the compact tissue of the wall of the upper portion is, therefore, by the continuance of the force after the fracture has taken place, driven into the cancellous tissue of the lower. This penetration may take place in several ways. If the extremity of the bone is large, and the force has been transmitted in nearly the direction of its axis, and all parts of the wall have yielded almost simultaneously, the whole of the end of the superior fragment may be driven into the lower one, and the two pieces may be thus locked or *nailed* one within the other. When, in such a case, the force is very great, the upper fragment may be so driven into the lower, that the latter may be completely smashed; it was to cases like this that Dupuytren gave the name of *fractures par ecrasement*.

But this mode of fracture, as might be expected from the number of circumstances which must combine to produce it, is rare; the more common form is produced when the force of the fall comes somewhat obliquely upon the radius. In this case, the line of fracture is, as in the last, nearly parallel to the plane of the articular surface, but since the force falls more on the posterior than on the anterior part of the latter, it follows that the posterior edge of the fractured compact tissue of the upper fragment begins first to penetrate into the cancellous tissue of the lower, and that the anterior edge, instead of penetrating, slides over upon the dorsal surface of the lower or carpal fragment. There is thus a dovetailing or reciprocal penetration of the two portions. And a similar arrangement of parts is seen, whether one traces them from behind forwards, or from without inwards. In the former direction, one comes first on the dorsal portion of the upper fragment, then on the same portion of the lower fragment, and then, in the same succession, on their palmar portions; and in the latter direction there is, on the outside the outer margin of the lower portion, then the outer margin of the upper one, and so on; for the outer edge of the upper portion in these cases always penetrates the cancellous tissue of the lower in such a manner that, if the line of its wall were carried on, it would cut off the styloid process. Hence it is that in all the cases of fracture of the radius near the wrist which M. Voillemier has examined long after the accident, he has found on a vertical section of the bone, a line of compact tissue continued straight downwards from the outer wall of the shaft into the interior of the cancellous tissue of the head. There are not two such lines of compact tissue, because that of the lower portion which should penetrate into the upper, is usually broken up and absorbed, in consequence of its extreme thinness.

Having found this state of parts in the great majority of instances, M. Vollemier denies the existence of oblique fractures of the lower end of the radius, and of those especially which M. Diday had described as fractures "tailles en biseau." These, he says, have been supposed to exist in consequence of the sensation which fragments, placed as described above, give when examined during life. The dorsal edge of the upper fragment projects somewhat lower down than the palmar edge of the lower one, for the former is pushed downwards over the lower fragment, the latter upwards over the upper one; and hence it seems to the touch as if the line of fracture were oblique from the palmar to the dorsal surface, and from above downwards. But such a state of parts has never been found on dissection. The condition is analogous in those rarer cases in which the lower fragment passes, not towards the dorsal but towards the palmar aspect of the upper one. Here there is only a seemingly oblique direction of the fracture, in consequence of the projecting edge of one fragment being higher up than that of the other.

From these pathological facts, which we believe to be exactly conformed to the truth, M. Vollemier gives a clear *rationale* of the symptoms, and then deduces the mode of treatment best to be followed.

The chief feature of that which he recommends is its simplicity, but he, without doubt, asserts a true principle when he says that in these fractures, even more than in most others, the apparatus must be adapted differently to almost every case.

An important addition to this paper is that part in which M. Veillemier speaks of the separation of the inferior epiphysis of the radius which may take place in consequence of severely twisting the wrist-joint. He was led to notice this, by having accidentally produced it in an attempt to dislocate the wrist of a dead body; and he subsequently convinced himself that either this separation, or a fracture of the lower end of the radius, without complete rupture of the surrounding fibrous tissues, might be thus produced during life. He relates two cases in which he believes it had occurred, and points out, as its chief signs, the absence of deformity where all the other characters of fracture are present, and a most severe pain at the ordinary situation of the boundary between the epiphysis and shaft, whenever any attempt at motion is made.—*Ibid, from Archives Générales de Medecin.* Mars, 1842.

PREVENTION OF LEAD COLIC.

Mr. Benson, the managing director at the British white lead works, Birmingham, says that the use of what he calls sulphuric beer by the workmen is an effectual preventive of the colic arising from the effects of the lead, and which, previously to the employment of the sulphuric beer, was exceedingly prevalent among the men. He was induced to try it from a statement made some time since, that sulphuric leamonade had been successfully used at a white lead manufactory in France. Its action must be effected by the chemical transformation of the poisonous carbonate into the innocuous sulphate of lead. The formula for the preparation of the beer is as follows;—Take of treacle, fifteen pounds; bruised ginger, half a pound; water, twelve gallons; yeast, one quart; bicarbonate of soda, one ounce and a half; sulphuric acid, one ounce and a half by weight. Boil the ginger in two gallons of water; add the treacle and the remainder of the water hot. When nearly cold, transfer it to a cask, and add the yeast, to cause fermentation. When this has nearly ceased, add sulphuric acid, previously diluted with eight times its quantity of water, and then the bicarbonate of soda, dissolved in a quart of water. Close up the cask, and in three or four days the beer will be fit for use. As acetous fermentation speedily takes place, particularly in hot weather, new supplies should be prepared as required. The object in adding the bicarbonate of soda is to give a pleasant briskness to the beverage. The sulphuric acid remains greatly in excess.—*Lancet*, Dec. 17, 1842.

ROBERTSON ON THE CAUSE OF CARIES OF THE TEETH.

Prior to the appearance of the first edition of Mr. Robertson's treatise, in 1835, the prevailing opinions concerning caries of the teeth were those of Fox and Bell; the former maintaining that the disease consists in an inflammation of the bony substance of the crown of a tooth, which secondarily affects the lining membrane of the organ, causing its separation, and a consequent decomposition of the solid parts; the latter insisting that caries commences in inflammation of the bone immediately under the enamel, from which, he says, the tooth, owing its imperfect vitalization, cannot recover, and dec and decay are the consequence.

Mr. Robertson, on the other hand, maintains th the remote cause of destruction of the teeth is the composition of food which lodges in the interst between them.

The inflammatory theory, then, is to the effect th the teeth decompose by vital action, commencing their interior, and proceeding to their surface. O author's theory is exactly the opposite, namely, th decay begins by chemical action upon the surfa of the teeth, and proceeds to their interior, and th inflammation is the consequence, and not the cau of caries. His arguments are chiefly derived fr the fact, that the teeth decay only in such situati as are favourable for the lodgment and decomposit of food, and never upon their smooth and even s faces; from their decaying in pairs, and at partic periods of life; from the ready relief which fill and filing afford, if decay be not too far advance from the disease commencing externally and proce ing inwards, and never conversely; and from circumstance, that artificial teeth are liable to same species of destruction as natural ones.

These arguments we apprehend to be perfe sound, and in accordance with the rules of comm sense and experience; for we cannot imagine a d ease, which owes its origin and progress to infl mation, to be susceptible of alteration or cure means which, of all others, are most calculated contribute to such action. But when the cause purely chemical, and owing primarily to a defect structure, it is not irrational to suppose that mech cal treatment will arrest or remedy it. It is on ground that we think the practical applicatio Mr. Robertson's theory particularly valuable. lieving, as he does, that inflammation is not cause of caries, but the consequence of it, and pendent upon the influence of atmospheric and o agencies upon the lining membrane of a tooth, urges the necessity of removing any decay that be apparent, *before the occurrence of pain;* for its commencement there is little hope of a per nent remedy. He insists upon the propriety of stantly using a tooth-brush, so that any particles decomposing food may be removed; and of an o sional inspection of the teeth by a dentist, that lurking decay may be arrested. He tells us these suggestions have wrought a consider change in his own practice—that people now a to have caries arrested, rather than to have teeth moved in consequence of its ravages; and he m tains that, if this plan were universally acted u tooth-ache would be comparatively unknown, the organs would be preserved in beauty and use ness to the remotest period of life.—*London Gaz.* Dec. 9, 1842.

REVIVAL AFTER FREEZING.

In the winter of 1828-9 in Ireland, Gaimard f that toads could be completely frozen, so that lay in small pieces between their muscles; their dies became quite hard, stiff and motionless, b easily and without any effusion of blood, so that short, every trace of life disappeared, and yet in or twelve minutes they could be revived by im sing them in very slightly warmed water. If were too quickly frozen they did not revive.—*and For. Med. Rev. from Bib. Universelle.*